

		FOR OFF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0046250

Facility Name: DOUGLAS REHABILITATION & CARE CENTER

Address: 3516 POWELL LANE MATTOON 61938
Number City Zip Code

County: COLES

Telephone Number: (217) 528-0044 Fax # (217) 528-3412

IDPA ID Number: 412079163001

Date of Initial License for Current Owners: 05/01/2003

Type of Ownership:

VOLUNTARY, NON-PROFIT
Charitable Corp.
Trust
IRS Exemption Code

X PROPRIETARY
Individual
Partnership
Corporation
"Sub-S" Corp.
X Limited Liability Co.
Trust
Other

GOVERNMENTAL
State
County
Other

In the event there are further questions about this report, please contact:
Name: BOB KAGDA Telephone Number: (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) ROBERT HEDGES
(Title) MEMBER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER

0046250 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	79	Skilled (SNF)	79	28,835	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	79	TOTALS	79	28,835	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	429	177	2,171	2,777	8
9	SNF/PED					9
10	ICF	17,380	4,656		22,036	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,809	4,833	2,171	24,813	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 86.05%

D. How many bed-hold days during this year were paid by the Department?
_____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 03/ 01 /03

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 2/28/03 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 79 and days of care provided 2,171

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED
CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number

DOUGLAS REHABILITATION & CARE C

#

0046250

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

Page 3

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	125,263	8,752	4,584	138,599		138,599		138,599			1
2	Food Purchase		94,514		94,514	(6,891)	87,623		87,623			2
3	Housekeeping	81,774	13,571		95,345		95,345		95,345			3
4	Laundry	24,606	9,835		34,441		34,441		34,441			4
5	Heat and Other Utilities			116,564	116,564		116,564	770	117,334			5
6	Maintenance	36,497	4,548	23,205	64,250		64,250	5,932	70,182			6
7	Other (specify):*			12,183	12,183		12,183		12,183			7
8	TOTAL General Services	268,140	131,220	156,536	555,896	(6,891)	549,005	6,702	555,707			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,066,580	141,080	10,825	1,218,485	(127,563)	1,090,922		1,090,922			10
10a	Therapy	19,916		205,948	225,864	(205,948)	19,916		19,916			10a
11	Activities	69,811	1,041		70,852		70,852		70,852			11
12	Social Services	30,278	170	4,086	34,534		34,534		34,534			12
13	CNA Training											13
14	Program Transportation			2,371	2,371		2,371		2,371			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,186,585	142,291	223,230	1,552,106	(333,511)	1,218,595		1,218,595			16
	C. General Administration											
17	Administrative	56,387		189,950	246,337		246,337	(123,812)	122,525			17
18	Directors Fees											18
19	Professional Services			81,322	81,322		81,322	(49,905)	31,417			19
20	Dues, Fees, Subscriptions & Promotions			15,987	15,987		15,987	(4,640)	11,347			20
21	Clerical & General Office Expenses	77,844	9,825	19,038	106,707		106,707	2,233	108,940			21
22	Employee Benefits & Payroll Taxes			254,496	254,496	6,891	261,387		261,387			22
23	Inservice Training & Education			1,162	1,162		1,162		1,162			23
24	Travel and Seminar							1,939	1,939			24
25	Other Admin. Staff Transportation			4,800	4,800		4,800	(1,695)	3,105			25
26	Insurance-Prop.Liab.Malpractice			50,564	50,564		50,564	1,769	52,333			26
27	Other (specify):*			26,164	26,164		26,164	(11,120)	15,044			27
28	TOTAL General Administration	134,231	9,825	643,483	787,539	6,891	794,430	(185,231)	609,199			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,588,956	283,336	1,023,249	2,895,541	(333,511)	2,562,030	(178,529)	2,383,501			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	DIETARY		
	DIETITIAN CONSULTANT XVIII B 35-2	4,584	
	REPAIRS & MAINTENANCE	0	
		0	4,584
3	HOUSEKEEPING		
		0	
		0	0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE	0	
		0	0
5	HEAT & OTHER UTILITIES		
	GAS HEAT	42,515	
	ELECTRICITY	33,794	
	WATER	34,295	
	CABLE TV - LOBBY	5,960	
		0	116,564
6	MAINTENANCE		
	GROUNDS MAINTENANCE	2,912	
	PAINTING & DECORATING	855	
	BUILDING REPAIRS	8,555	
	MAINTENANCE TRAVEL	0	
	EQUIPMENT MAINTENANCE & REPAIR	5,560	
	ELEVATOR MAINTENANCE & REPAIR	0	
	OUTSIDE LABOR	0	
	EXTERMINATING SERVICE	1,305	
	FIRE SERVICE	4,018	
		0	
		0	
		0	23,205
7	OTHER		
	SCAVENGER	12,183	
	SECURITY SERVICE	0	12,183
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES XVIII B 36-2	0	0

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING XVIII C 53-2		
	LABORATORY & XRAY EXPENSE	9,535	
	PURCHASED SERVICES	0	
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,290	
	PHARMACY CONSULTANT XVIII B 39-2	0	
	UTILIZATION REVIEW FEES XVIII B __-2	0	
	PHYSICIANS XVIII B __-2	0	
	PSYCHIATRIC XVIII B __-2	0	
	RN CONSULTANT XVIII B 38-2	0	
		0	
		0	10,825
10a	THERAPY		
	PHYSICAL THERAPY SERVICES	109,963	
	SPEECH THERAPY SERVICES	19,040	
	OCCUPATIONAL THERAPY SERVICES	76,945	
	REHABILITATION CONSULTANT XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0	205,948
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS	0	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0	
		0	0
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES	0	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0	
	SOCIAL WORKER XVIII B 45-2	4,086	
		0	4,086
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS XIII	0	0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION	2,371	2,371
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B 189,950	189,950
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C 7,543	
	ADMINISTRATIVE CONSULTANTS	XIX C 0	
	PROFESSIONAL FEES	XIX C 73,779	
		0	81,322
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F 0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F 5,292	
	EMPLOYEE WANT ADS	XIX F 1,152	
	CONTRIBUTIONS	VI 20 XIX F 0	
	DUES & SUBSCRIPTIONS	XIX F 4,990	
	LICENSES & PERMITS	XIX F 2,265	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F 0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F 0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F 0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F 0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F 2,288	15,987
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0	
	EQUIPMENT REPAIR & MAINTENANCE	881	
	OUTSIDE CLERICAL SERVICES	0	
	PENALTIES / OVERDRAFT CHARGES	VI 18 6,009	
	HOME OFFICE EXPENSE	0	
	THEFT & DAMAGE LOSS	0	
	TELEPHONE	12,148	
	MESSENGER SERVICE	0	
		0	19,038

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D 120,398	
	UNEMPLOYMENT COMPENSATION	XIX D 26,402	
	WORKERS COMPENSATION INSURANCE	XIX D 88,712	
	HOSPITALIZATION INSURANCE	XIX D 11,908	
	EMPLOYEE BENEFITS - OTHER	XIX D 7,076	
	EMPLOYEE PHYSICAL EXAMS	XIX D 0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D 0	
	PENSION/PROFIT SHARING PLANS	XIX D 0	
	CHICAGO HEAD TAX	XIX D 0	254,496
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	1,162	1,162
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G 0	
	TRAVEL	XIX G 0	
		0	
		0	0
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	4,800	4,800
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	50,564	50,564
27	OTHER		
	BAD DEBTS	VI 24 26,164	
			26,164

GRAND TOTAL COLUMN 3 OTHER

1,023,249

DOUGLAS REHABILITATION & CARE CENTER
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2005

TOTAL FOOD PURCHASE	94,514	PATIENT MEALS	74439
LESS SALES TAX	0	ADD EMPLOYEE MEALS	5840
	-----		-----
NET FOOD	94,514	TOTAL MEALS/YEAR	80279
TOTAL PATIENT CENSUS	24,813	NET FOOD	94514
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	80279

TOTAL PATIENT MEALS	74439	COST PER MEAL	1.18
		TIME EMPLOYEE MEALS	5840
ADD # EMPLOYEE MEALS/DAY	16		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	6891
	-----		=====
TOTAL EMPLOYEE MEALS	5840		

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			2,360	2,360		2,360	(412)	1,948			30
31	Amortization of Pre-Op. & Org.			1,400	1,400		1,400		1,400			31
32	Interest			30,004	30,004		30,004	1,119	31,123			32
33	Real Estate Taxes			29,057	29,057		29,057		29,057			33
34	Rent-Facility & Grounds			346,020	346,020		346,020		346,020			34
35	Rent-Equipment & Vehicles			15,524	15,524		15,524		15,524			35
36	Other (specify):* Comp Software			7,715	7,715		7,715		7,715			36
37	TOTAL Ownership			432,080	432,080		432,080	707	432,787			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					333,511	333,511		333,511			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,253	43,253		43,253		43,253			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			43,253	43,253	333,511	376,764		376,764			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,588,956	283,336	1,498,582	3,370,874		3,370,874	(177,822)	3,193,052			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,058)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(6,009)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(26,164)	27		24
25	Fund Raising, Advertising and Promotional	(5,292)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(64,438)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (102,961)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(74,861)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (74,861)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (177,822)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
DOUGLAS REHABILITATION & CARE CENTER

Page 5A

ID# 0046250
Report Period Beginning: 01/01/2005
Ending: 12/31/2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING TRAVEL	\$ (1,695)	25	1
2	MARKETING SALARY	(12,158)	21	2
3			19	3
4	DATA PROCESSING-HEALTHCARE HORIZONS	(21,750)	19	4
5	PROFESSIONAL FEES-ELITE CARE CORP	(28,835)	19	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(64,438)		49

Summary A

12/31/2005

[illegible]

Summary B

12/31/2005

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				HI CARE	SPRINGFIELD	MANAGEMENT
				MANAGEMENT		
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	\$ 189,950	HI CARE MANAGEMENT		\$	(189,950)	1
2	V	5	UTILITIES				770	770	2
3	V	6	MAINTENANCE				5,932	5,932	3
4	V	17	OFFICER SALARY				48,401	48,401	4
5	V	17	DIRECTOR OF OPERATIONS				6,673	6,673	5
6	V	17	DIRECTOR OF FINANCE				11,064	11,064	6
7	V	19	PROFESSIONAL FEES				680	680	7
8	V	20	DUES & SUBSCRIPTIONS				652	652	8
9	V	21	OFFICE EXPENSE				20,400	20,400	9
10	V	24	TRAVEL & SEMINARS				1,939	1,939	10
11	V	26	INSURANCE				1,769	1,769	11
12	V	27	PAYROLL TAXES & GRP INS				15,044	15,044	12
13	V								13
14	Total			\$ 189,950			\$ 113,324	\$ * (76,626)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	DEPRECIATION	\$	H & I PROPERTIES		\$ 646	\$ 646	15
16	V	32	INTEREST		H & I PROPERTIES		1,119	1,119	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 1,765	\$ * 1,765	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number DOUGLAS REHABILITATION & CARE C # 0046250 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ROBERT HEDGES	PRESIDENT	OFFICE MGMT.						\$		1
2	TOTAL SALARY RECEIVED FROM HI CARE \$170,000			37.5 %				SALARY	24,201	17-8	2
3											3
4											4
5											5
6	WILLIAM IRVINE	VICE-PRESIDENT	OFFICE MGMT.								6
7	TOTAL SALARY RECEIVED FROM HI CARE \$170,000			37.5%				SALARY	24,200	17-8	7
8											8
9											9
10											10
11	MARTHA IRVINE	BOOKKEEPING	BOOKKEEPING								11
12	TOTAL SALARY RECEIVED FROM HI CARE \$6672								950	21-8	12
13								TOTAL	\$ 49,351		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER # 0046250 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization HI CARE MANAGEMENT
Street Address 1625 SOUTH SIXTH STREET
City / State / Zip Code SPRINGFIELD, IL. 62703
Phone Number (217)528-0044
Fax Number (217)528-3412

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PER RESIDENT DAY	174,304	7	\$ 5,408	\$	24,813	\$ 770	1
2	6	MAINTENANCE	PER RESIDENT DAY	174,304	7	41,669	34,507	24,813	5,932	2
3	17	OFFICER SALARY	PER RESIDENT DAY	174,304	7	340,000	340,000	24,813	48,401	3
4	17	DIRECTOR OF OPERATIONS	PER RESIDENT DAY	174,304	7	46,873	46,873	24,813	6,673	4
5	17	DIRECTOR OF FINANCE	PER RESIDENT DAY	174,304	7	77,723	77,723	24,813	11,064	5
6	19	PROFESSIONAL FEES	PER RESIDENT DAY	174,304	7	4,774		24,813	680	6
7	20	DUES & SUBSCRIPTION	PER RESIDENT DAY	174,304	7	4,580		24,813	652	7
8	21	OFFICE EXPENSE	PER RESIDENT DAY	174,304	7	143,304	89,662	24,813	20,400	8
9	24	TRAVEL & SEMINARS	PER RESIDENT DAY	174,304	7	13,622		24,813	1,939	9
10	26	INSURANCE	PER RESIDENT DAY	174,304	7	12,425		24,813	1,769	10
11	27	PAYROLL TAXES & GRP INS	PER RESIDENT DAY	174,304	7	105,677		24,813	15,044	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 796,055	\$ 588,765		\$ 113,324	25

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER # 0046250 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization H & I PROPERTIES
Street Address 1625 S SIXTH STREET
City / State / Zip Code SPRINGFIELD IL 62703
Phone Number (217) 528-0044
Fax Number (217) 528-0044

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1	30	DEPRECIATION	PER LICENSE BED	639	7	\$ 5,226	\$ 79	\$ 646	1
	2	32	INTEREST	PER LICENSE BED	639	7	9,051	79	1,119	2
	3									3
	4									4
	5									5
	6									6
	7									7
	8									8
	9									9
	10									10
	11									11
	12									12
	13									13
	14									14
	15									15
	16									16
	17									17
	18									18
	19									19
	20									20
	21									21
	22									22
	23									23
	24									24
	25	TOTALS				\$ 14,277	\$		\$ 1,765	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$		\$			\$	1
2													2
3													3
4	related party office-us bank		X	MORTGAGE						6/29/12	0.0635	1,119	4
5	MEMBERS LOANS	X		WORKING CAPITAL	INT		100,000	100,000	DEMAND			7,000	5
	Working Capital												
6	ILLINI BANK		X	WORKING CAPITAL	INTEREST	REVOLV		111,671	REVOLV	PRIME +		17,911	6
7	ILLINI BANK		X	WORKING CAPITAL	1580 + INT	9/25/03	75,000	45,525	9/25/08	0.0964		5,093	7
8													8
9	TOTAL Facility Related						\$ 175,000	\$ 257,196			\$ 31,123	9	
	B. Non-Facility Related*												
10	IRS, IDR, ETC		X	LATE FEES									10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$	14
15	TOTALS (line 9+line14)						\$ 175,000	\$ 257,196			\$ 31,123	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2004 report.			\$	36,282	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	32,669	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(3,613)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	32,670	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	29,057	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2000		8	
		2001		9	
		2002	35,123	10	
		2003	30,417	11	
		2004	32,669	12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL				13	FROM R. E. TAX STATEMENT FOR 2004 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

DOUGLAS REHABILITATION & CARE CENTER

COUNTY

COLES

FACILITY IDPH LICENSE NUMBER

0046250

CONTACT PERSON REGARDING THIS REPORT

BOB KAGDA

TELEPHONE (847) 675-3585

FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)		(B)	(C)	(D)
Tax Index Number		Property Description	Total Tax	<u>Tax</u> Applicable to Nursing Home
1.	07-1-00300-000	NURSING HOME	\$ 30,342.00	\$ 30,342.00
2.	07-1-00300-001	NURSING HOME	\$ 1,971.00	\$ 1,971.00
3.	07-1-00572-000	NURSING HOME	\$ 356.00	\$ 356.00
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 32,669.00	\$ 32,669.00

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

B. General Construction Type:

Exterior

Frame

Number of Stories

C. Does the Operating Entity?

☐ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☒ (c) Rent from Completely Unrelated Organization.

D. Does the Operating Entity?

☐ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☒ YES

☐ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs: LEGAL COSTS

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$		4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	INSULATION			2004	10,441	380	27.5	380		523	9
10	REPLACE HEAT & CHILL LINES			2005	3,245	5	27.5	5		5	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	H & I PROPERITES-OFFICE BUILDING			2005	32,513	646	39	646		646	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 46,199	\$ 1,031		\$ 1,031	\$	\$ 1,174	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 7,060	\$ 1,130	\$ 706	\$ (424)	10YRS	\$ 1,059	71
72	Current Year Purchases	4,227	845	211	(634)	10YRS	211	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 11,287	\$ 1,975	\$ 917	\$ (1,058)		\$ 1,270	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 57,486	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 3,006	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 1,948	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,058)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,444	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: ELITE MATTOON LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		79	2/28/03	\$ 346,020	10		3
4	Additions							4
5								5
6								6
7	TOTAL		79		\$ 346,020			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ 15,524 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$ 0	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning 2/28/03

Ending 2/28/13

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	\$ 346,020
13.	/2007	\$ 346,020
14.	/2008	\$ 346,020

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-8	hrs	\$		\$ 76,945	\$		\$ 76,945	1
2	Licensed Speech and Language Development Therapist	39-8	hrs			19,040			19,040	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-8	hrs			109,963			109,963	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescrpts				89,955		89,955	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	39-8					37,608		37,608	13
14	TOTAL			\$		\$ 205,948	\$ 127,563		\$ 333,511	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 24,675	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 35,000)	414,935		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	67,772		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	20,457		8
9	Other(specify): R/E ESCROW	45,435		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 573,274	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	13,686		15
16	Equipment, at Historical Cost	34,432		16
17	Accumulated Depreciation (book methods)	(28,598)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	7,000		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(3,967)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 22,553	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 595,827	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 411,099	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	157,143		29
30	Accrued Salaries Payable	55,114		30
31	Accrued Taxes Payable (excluding real estate taxes)	24,591		31
32	Accrued Real Estate Taxes(Sch.IX-B)	32,670		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 680,617	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	100,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 100,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 780,617	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (184,790)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 595,827	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (138,157)	1
2	Restatements (describe):		2
3	ROUNDING	(2)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (138,159)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(46,631)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (46,631)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (184,790)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,130,057	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,130,057	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	183,932	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 183,932	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	8,220	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 8,220	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,145	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,145	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	OTHER INCOME	889	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 889	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,324,243	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	555,896	31
32	Health Care	1,552,106	32
33	General Administration	787,539	33
	B. Capital Expense		
34	Ownership	432,080	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	43,253	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,370,874	40
41	Income before Income Taxes (line 30 minus line 40)**	(46,631)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (46,631)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.
TAX RETURN PREPARED ON CASH BASIS

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,943	2,083	\$ 55,635	\$ 26.71	1
2	Assistant Director of Nursing	1,922	2,087	49,486	23.71	2
3	Registered Nurses	2,484	2,747	52,923	19.27	3
4	Licensed Practical Nurses	17,642	19,302	296,001	15.34	4
5	CNAs & Orderlies	48,237	52,154	538,435	10.32	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,702	1,927	19,916	10.34	8
9	Activity Director	1,768	2,099	19,962	9.51	9
10	Activity Assistants	5,147	5,593	49,849	8.91	10
11	Social Service Workers	1,895	2,055	30,278	14.73	11
12	Dietician					12
13	Food Service Supervisor	1,907	2,083	29,574	14.20	13
14	Head Cook	4,488	5,116	42,740	8.35	14
15	Cook Helpers/Assistants	7,053	7,340	52,949	7.21	15
16	Dishwashers					16
17	Maintenance Workers	2,302	2,541	36,497	14.36	17
18	Housekeepers	9,409	10,011	81,774	8.17	18
19	Laundry	3,321	3,512	24,606	7.01	19
20	Administrator					20
21	Assistant Administrator	1,812	2,083	56,387	27.07	21
22	Other Administrative					22
23	Office Manager	1,889	2,091	35,791	17.12	23
24	Clerical	3,443	3,709	42,053	11.34	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	935	1,007	9,089	9.03	31
32	Other Health Care(specify)	3,488	3,896	65,011	16.69	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	122,787	133,436	\$ 1,588,956 *	\$ 11.91	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	119	\$ 4,584	1-3	35
36	Medical Director		0	9-3	36
37	Medical Records Consultant	24	1,290	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		0	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant	56	4,086	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	199	\$ 9,960		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		\$		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. IL HEALTH CARE ASSOC \$4,361
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,095 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? X YES _____ NO _____
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 43,253
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 6,891 Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees